VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
DMAS 420A

PHYSICIAN RECERTIFICATION

(This form may be duplicated)

Name: _____ Medicaid#:_____

Hospice Provider: _____ Provider NPI #:_____

Having reviewed this individual's care and normal course of illness, I certify that in my best judgment, this individual remains appropriate for hospice care, on the following dates.

Subsequent benefit period: From ____/____/____ to ____/____/____

_____ ____/____/____
Physician Member of Hospice ID team or Hospice Medical Director Signature/Date

Subsequent benefit period: From ____/____/____ to ____/____/____

_____ ___/____/____
Physician Member of Hospice ID team or Hospice Medical Director Signature/Date

Subsequent benefit period: From ____/____/____ to ____/____/____

_____ ____/____/____
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Subsequent benefit period: From ____/____/____ to ____/____/____

_____ ____/____/____
Physician Member of Hospice ID team or Hospice Medical Director Signature/Date

Subsequent benefit period: From ____/____/____ to ____/____/____

_____ ____/____/____
Physician Member of Hospice ID team or Hospice Medical Director Signature/Date

***Hospice consists of the initial two (2) ninety-day periods and then the subsequent sixty-day periods extending until the individual is no longer on Hospice.**